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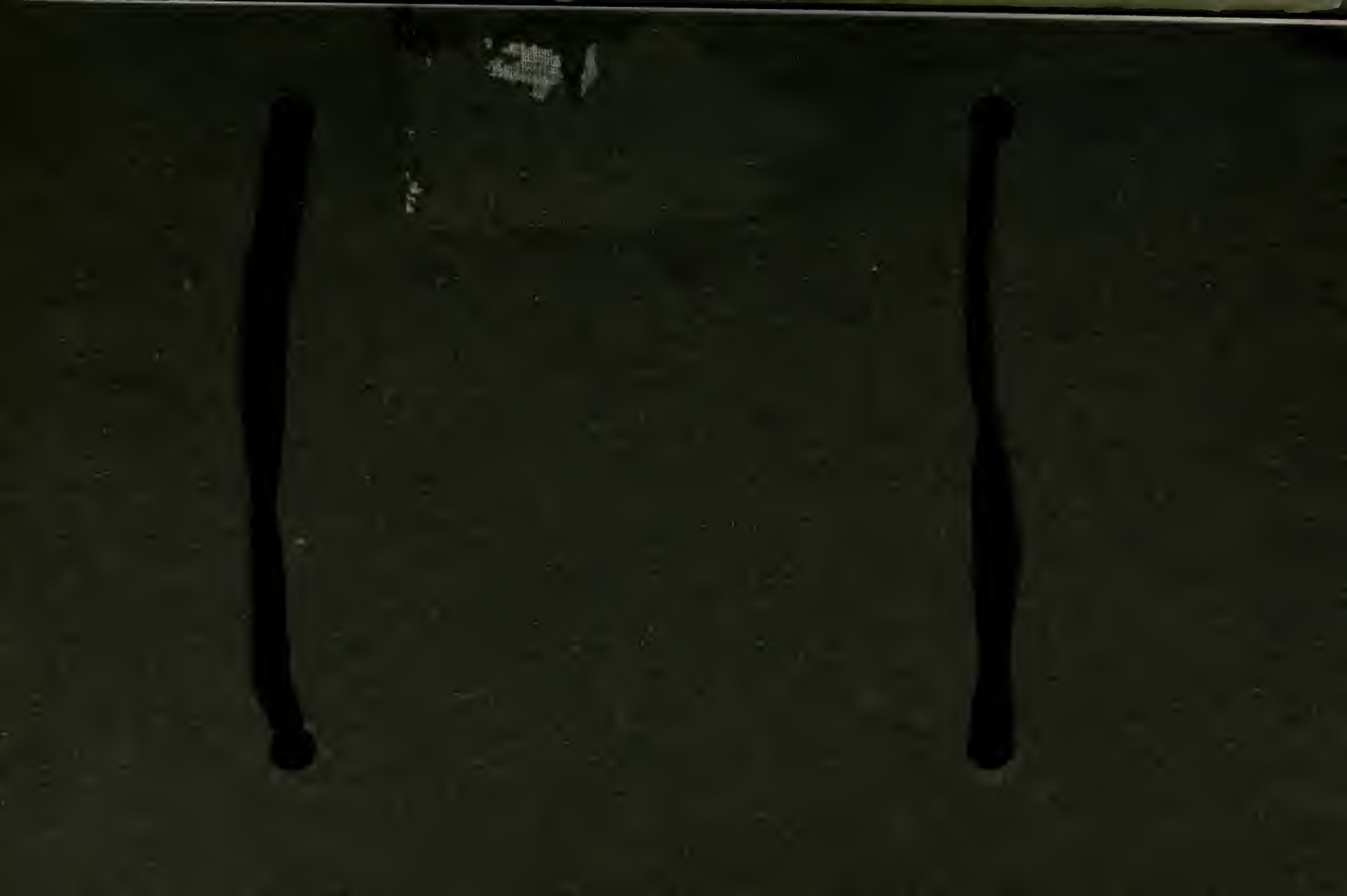

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INCLUDING SYPHILIS

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Subscriptions and all business communications should be addressed to The Grafton Press, 70 Fifth Avenue.

Communications relating to the editorial department, exchanges, and books for review, should be addressed to A. D. MEWBORN, M.D., EDITOR, 50 West Thirty-seventh Street, New York.

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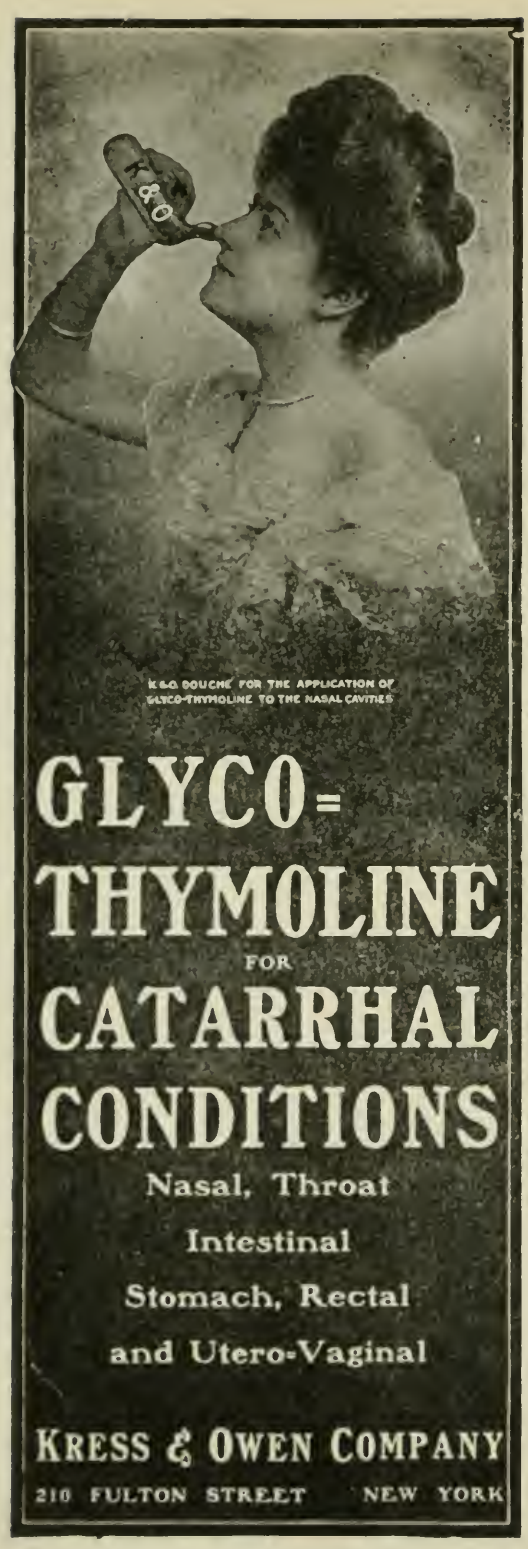

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VOL. XXVI OCTOBER, 1908 NO. 10

LYMPHANGIOMA TUBEROSUM MULTIPLEX.

M. L. Heidingsfeld, M. D., Cincinnati.

Presented to the Deutsche Naturforscher, Cologne, September 20-26, 1908.

KAPOSI has described a form of dermatologic affection, to which he gave the name of lymphangioma tuberosum multiplex, the clinical prototype of which, though by no means of frequent occurrence, has been often enough encountered and sufficiently well recognized to give it a well deserved place in dermatologic nosology. The lesions are conical or oval in outline, and vary from a pin-head to a pea or even larger in size. They are firmly imbedded in, and freely movable with the skin, covered with normal overlying epidermis, by which they are often so concealed that their presence is revealed only by touch, or when tension is exercised on the tissues in which they are imbedded. They are firm to the touch, insensitive to pressure, and possess a discrete, bilateral almost symmetrical distribution, and a somewhat crowded and indefinite grouping. The lesions, individually as regards their long axis, and collectively as regards their position to each other, show a marked tendency to arrange themselves in conformity to the lines of cleavage, and occasionally they are placed end to end to form an elongated patch. The lesions vary somewhat in color, from that of the normal skin to pink, yellow, sepia or reddish brown. Subjective symptoms are rarely associated.

The anterior aspect of the chest, from the clavicles to the navel, and particularly the sternal area, is most commonly and constantly involved. The area over the sterno-clavicular junction is another site of predilection, although the sides of the thorax, back, and other portions of the body are occasionally involved. The lesions usually manifest themselves early in life, develop slowly, multiply steadily, and reach a relatively full development in early adult life. The older and larger lesions occasionally undergo a mild ulcerative inflammation, and spontaneous involution.

The pathologic clinical name lymphangioma tuberosum multiplex, which Kaposi has given to this affection, has proven to be ill-chosen, and inappropriate, and is worthy of adoption merely on the grounds of priority, and common usage. The pathology of this fairly constant clinical type of affection has been found to be exceedingly varied, and so closely akin at times to types of affection, so totally dissimilar and different in their physical and clinical characters, that a generic term of histologic import seems to be ungermane. Its pathology has been found to be identical at times with that already rather large class of cases which have been variously designated, under the names of multiple benign cystic epithelioma, etc., and with that very large and commonly encountered group, characterized by usually only one or two small glistening, pearly-white, depressed, button-like, isolated lesions of the face, with milia-like borders, as described by Hartzell.

To further accentuate the futility of establishing lymphangioma tuberosum multiplex upon a histo-pathologic basis and with the hope of shedding some additional light to those who are actively engaged in the thus far indefinite and indeterminate investigation as to the origin of these dermatologic new-growths from epithelial or endothelial tissue, and their derivation from epidermis, hair follicles, sweat glands, ducts, lymph- or blood-vessels, the writer wishes to report the following typical clinical case with an unusual and possibly unique histopathology:

A. H., negro, aged 26 years, born at Charlotte, N. C., the eighth child of seventeen children, the seven youngest of whom are all dead. Mother, father, four brothers and five sisters are all living and in the enjoyment of good health. Patient and his mother are the only members of the family, to the patient's knowledge, who have shown any trace of the affection.

The eruption consists of small rounded or oval lesions, pin-head to a pea or somewhat larger in size and normal in color, conforming in this respect to the rest of the skin, which in his case is the type of a $\frac{3}{4}$ full-blooded negro. The lesions are firm to the touch, insensitive to pressure, imbedded in and freely movable with the epidermis. The epidermis conceals from view the vast majority of the lesions, but the latter are brought distinctly into view, if the intervening skin in which they are imbedded is placed upon the stretch. They are distributed for the most part over the anterior aspect of the chest, particularly over the sternum, and chiefly within a triangular area bounded by the nipples and umbilicus, wherein

several hundred lesions are closely and somewhat irregularly grouped. The long diameter of the lesion is usually placed transversely to the long axis of the body. They follow the lines of cleavage in their arrangement and distribution. A second area of closely grouped lesions is situated in the hollow at the base of the neck and over the sterno-clavicular junction. A single lesion is situated over the right and several over the left scapula, and a few lesions which have made their appearance during the past eighteen months are situated in the axillæ, and over the lateral aspects of the thorax. Eyelids, face, extremities, and lower portion of the trunk are free from lesions. The involved areas show a number of slightly depressed, pigmented cicatrices, which the patient states were the site of former lesions, which underwent a mild inflammatory ulceration and spontaneous involution. The affection has been present as long as patient can distinctly remember, but the lesions have steadily multiplied in number, increased in size, and enlarged in their extent. Patient has been entirely free from itching, pain, and other subjective or objective symptoms, save those already enumerated. Patient is married but without progeny, and the only other member of his numerous family similarly affected is his mother, who, according to the patient's statement, presents the same character of eruption, and with the same development, course, and distribution. The case came to my notice on February 14th, 1905, and has been under more or less constant personal observation the past three years, and during that time relatively little change has been noted in the appearance and development of the affection. Lesions were excised for histologic examination on February 14th and 28th, and December 1st, 1905, and form the basis of the following report:

Pathology.

The lesions are cysts situated in the derma at various levels, some in the lower depths close to the subcutaneous fat and considerably below the level of the lowest hair follicles. Those nearest to the epidermis are situated just beneath the pars papillaris, and the majority are placed between these levels in the unusually broad layer of cutis vera. The epidermis preserves its normal character, and sweat glands, ducts, hair follicles, and sebaceous glands are in all respects normally preserved and regularly distributed. The cysts for the most part are oval in outline, with the long axis slightly oblique to the surface perpendicular. The cysts are well imbedded in and encapsulated by a dense wall of connective tissue, and the wall is lined with usually one or more layers of well preserved epithelial

cells, with large oval nuclei, showing karyokinetic changes, with the innermost cells undergoing a rapid fatty degeneration. The cysts are filled with a soft cheesy-like mass of epithelial debris, and a large amount of small lanugo hair, richly distributed throughout the cheesy contents or concentrically coiled into dense locks. The contents of the cysts is soft and pliable in nature, and can be preserved in section only in the smallest cysts, the larger lesions containing mere remnants at some of the borders, and appear from loss of contents as large oval spaces, lined with several layers of epithelial cells. Cysts in various stages of development are present in all the specimens examined, and tissue removed for the examination of a single macroscopic lesion, contained an abundance of microscopic cysts, of the character already portrayed. The cysts preserve a uniform histological structure and character, and all the cysts contain an abundance of lanugo hair, whenever the contents can be preserved and is not mechanically dislodged in the process of sectioning, staining and mounting. The cysts bear a pathologic analogy to the dermoid cysts of the ovary, and judging from their deeply placed character, and from the absence of any recognizable relationship with the surrounding normal hair follicles, it must be inferred that they owe their origin to, and embryological derivation from, misplaced epithelial tissue of the epiblast. No other pathologic change of any moment could be recognized. There is no evidence of any interlacing epithelial strands, and colloid cysts, the pathologic prototype of this class of cases. Lymph- and blood-vessels are in all respects normal and are in no way involved in the pathologic process, and the epidermis, follicles and glandular elements are in all respects normal.

The consideration of this case must of necessity place a peculiar construction on our present knowledge and conception of the class of cases thus far considered under the general head of lymphangioma tuberosum multiplex and its various synonyms (syringo-cystoma, syringo-cystadenoma, hydradenome eruptif, hemangio-endothelioma, &c., &c.). The case is a well defined clinical example of a generally well recognized form of dermatologic affection, which received a clear and classical interpretation at the hands of the first to recognize and describe it, and from a relatively large number of investigators, who have followed him.

Its clinical prototype has been carefully enumerated by Kaposi, Jacquet and Dariér, Török, Quinquaud, Lesser and Beneke, Jarisch, Kromayer, Herxheimer, Thimm, Charles White, Crocker, Neumann, Brocq, and others. The plates which portray the clinical appearance

of Thimm's case, is almost a counterpart of its clinical aspects. The only unusual clinical features of the case, are its occurrence in a negro—the first instance on record to the personal knowledge of the author and the tendency inherited from the mother. The clinical observation that the cases of so-called multiple benign cystic epithelioma frequently inherit the tendency, and those of lymphangioma tuberosum multiplex rarely if ever inherited it, has been used as a point for the differential diagnosis and arbitrary separation of these, in some respects clinically and pathologically similar affections.

The histopathology of the case is doubtless unique and possesses but one prototype of somewhat doubtful similarity which was clinically diagnosed by Pollitzer as xanthoma tuberosum multiplex, and the histopathology revealed the lesions to be dermoid cysts. The unusual pathological character of the case recalls the cases of an osteoma cutis (one of which is in the author's experience), where laminated bone with all the characteristic elements, bone cells, Haversian canals, canaliculi, bone corpuscles, &c., are situated entirely in the cutis, independent of all other structures. This mesoblastic structure in purely epiblastic tissue, clearly demonstrates that some of these new-growths must take their origin from misplaced embryonic remains.

The histopathology of lymphangioma tuberosum multiplex is by no means of a uniform character, as evidenced not only by the variations in the descriptive reports, but also in the efforts of Török, Crocker, Unna, Blaschko, Neumann, Dohi, Gassmann, Fiocco, White and others on the one hand to seek an epithelial derivation from sweat glands, and a development from embryonic remains, with Kaposi, Elsching, Jarisch, Guth, Wolters, Waldheim, Alexander, Lesser and others who ascribe to the condition an endothelial character and a derivation from lymph- and blood-vessels. The striking similarity which the histopathology of this affection bears to that class of dermatologic affection described under the general name of multiple benign cystic epithelioma, or epithelioma adenoides cysticum, and some of its other synonyms, and to those not uncommon, small, often solitary, firm depressed button-like, disc-shaped lesions, yellowish white, glistening in appearance, and often studded with minute milia, shrouds it with no inconsiderable degree of obscurity. It seems that Kaposi, and those who followed in his wake, were particularly unfortunate to have attached a descriptive pathologic name to an affection which subsequent investigation has shown to possess an indefinite pathology, and one shared by widely different clinical types. In

this observation I must concur with Hartzell, that "neoplasms differing widely in origin (?) and nature may resemble one or another so closely histologically as to be indistinguishable, which is unlikely." It seems probable that there is an intimate and common relationship between these various affections, and possibly a larger group of cases, which thus far have a separte entity and nomenclature.

Their present-day distinction is clinical rather than pathological, and the pathological resemblance of the various groups for each other is more strikingly similar and uniform, than the pathologic traits of the individual cases for each other. Charles White calls attention to the utter confusion which exists between clinician and clinico-pathologist regarding the identity of these conditions, and pleads for a separation of the various types upon combined clinical and pathological grounds. In that event the case herewith reported must form an affection for itself. It seems more rational and simpler to regard these various affections as new-growths resulting from the developmental errors of embryonic remains, which partake at times the character of one or the other elements of the skin epidermis, gland lymph- or blood-vessel, &c., without specially influencing the clinical nature, character or subsequent course of the affection. The pathology may thus present a somewhat varied character, but the clinical type, lymphangioma tuberosum multiplex, adenoma sebaceum, multiple benign cystic epithelioma, or linear nævus remains constant.

The uncertain character of the pathology of the affection is well illustrated by Guth and Dohi. Both report the same case, and the one believes the lesions to be of unquestioned hæmangiomatous derivation, the epithelial strands incorporating red corpuscles and anastomosing with blood vessels; the other is firmly convinced that they are of epithelial origin, from misplaced ducts of sudoriferous glands.

Most of the authors who have investigated these cases are of the opinion that these new-growths owe their origin and development to misplaced embryonic remains, and attention has been called to this feature as a point of common resemblance between lymphangioma tuberosum multiplex, adenoma sebaceum, multiple benign cystic epithelioma, and linear nævi. The relationship of adenoma sebaceum with the nævi has been too generally observed to require further comment, but of particular interest is the observation of Francois-Danville that the association of vascular and pigmented nævi in the case syringo cystadenoma, originally reported by Jacquet fourteen

years prior, led him to class the affection with the nævi. The probable common embryonic development of these enumerated affections, together with other common clinical and pathological features, doubtless serve to establish a close relationship and an intricate differentiation. Nevertheless it is a matter of convenience to maintain the separate groups as they now exist, upon the most tenable clinical grounds. While exception can be taken to the nomenclature of these affections, it is probably wisest by reason of priority, long usage, and custom, and a varied clinical character, to leave it, with our present state of indeterminate knowledge, unchanged.

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DESCRIPTION OF PLATES.

Fig. 1.—Lymphangioma tuberosum multiplex. Lesions scattered for the most part of the abdomen and neck, multiply in number and spring into prominence when tension of the skin is exerted over the affected areas.

Fig. 2.—Lymphangioma tuberosum multiplex. Two microscopic cysts filled with debris and lanugo hair, situated in a mass of dense connective tissue in the lower layers of the cutis. The lesions are oval in outline, parallel and obliquely placed in close proximity to each other. Winkel, Oc. 2. Obj. 1.

Fig. 3.—Lymphangioma tuberosum multiplex. Cyst of the same character as those of Fig. 2, showing a thin dense wall, a lock of lanugo hair and other hairs on cross section, together with the dense character of the surrounding connective tissue. Oc. 1. Obj. 3.

Fig. 4.—Lymphangioma tuberosum multiplex. Lock of lanugo hair taken from one of the cysts strongly magnified, containing both cortical and medullary pigment and other characteristics of normal hair. Oc. 2. Obj. 5.

PLATE XLII.—To Illustrate Dr. M. L. Heidingsfeld's Article.

Fig. 1.

Fig. 2.

PLATE XLIII. To Illustrate Dr. M. L. Heidingsfeld's Article.

Fig. 3.

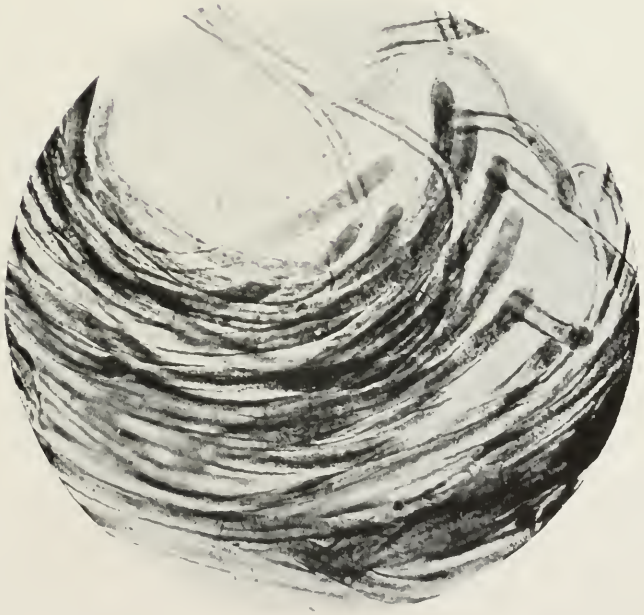

Fig. 4.

OSTEOMA CUTIS

Stopford Taylor, M. D., and R. W. Mackenna, M. A., M. D.,
Physicians to the Liverpool Skin Hospital.

Deposits of bone are occasionally, though very rarely, found in the soft tissues of the body, and cases are on record in which osseous formations have been met with in the parotid gland, the lungs and even the brain. There is no case, however, on record either in the literature of the journals or in that which has found a more permanent abiding place in the text-books of a condition which we have ventured to designate as Osteoma Cutis.

CASE.

H. C., Female, aged 15 months—Was brought to the Liverpool Skin Hospital in November, 1907. The child's family history was good. The father and mother were both living and healthy, though the mother had a slight degree of anæmia. There was no history of syphilis, alcoholism, rheumatism, rickets or other bone disease in the family, nor any stigma of nervous affections. The patient was the fifth child and the only girl in the family. During the latter half of her pregnacy with this child, the mother had several attacks of severe flooding, for which no cause could be ascertained. Apart from these hæmorrhages the mother's health during gestation was good, her food was ample, and her general hygienic surroundings were satisfactory. There was no history of "maternal impressions." Parturition occurred about three weeks before the appointed time. Labour was very prolonged, and delivery was instrumental.

At birth the child was puny and was not expected to live, but the mother suckled her and she throve so that when first seen by us she was of average size and weight. Up till that time she had had no illnesses. When she was about five months old, the mother noticed a faintly purple stain on the left thigh a little above the knee joint.

It was rectangular in shape and about one-third of an inch long and one-eighth of an inch broad. On feeling the spot the

mother observed that it was hard and gristly. Shortly afterwards she noticed two similar but smaller spots with the same characteristics on the anterior chest wall, about the level of the xiphoid cartilage. Since then the mother has noticed similar spots develop on other parts of the body.

Status Præsens—The following was the condition on the first visit of the child to the hospital:—On the outer side of the left thigh, just above the knee-joint there was a purplish patch of skin about one inch in length by three-quarters of an inch in breadth. On the surface of the discolored area there were several small pearly spots, each about the size of a millet seed. On palpation one felt a gristly plaque lying apparently in the deeper layers of the skin. The upper layer of the skin was firmly adherent and could not be moved on the plaque. The plate or plaque had well defined edges, and the surrounding tissues were normally soft. The plate was resilient and elastic, and could be bent by pressure, but regained its original shape as soon as the pressure was removed.

Below the knee, on the inner aspect of the right leg, were four minute purplish patches, the largest of which was not bigger than a split-pea. On palpation the same general characters were met with as in the larger plaques.

On the anterior chest wall, symmetrically on each side of the mid-line, and at a distance of an inch from it, at the level of the xiphoid were two smaller areas. That on the right side was the larger, being half an inch broad, while that on the left side was a quarter of an inch in diameter.

Over all, the skin was firmly adherent. Posteriorly over the left half of the thorax, at the level of the 8th, 9th, and 10th ribs, there was a number of shotty deposits, similar to those already described. On the left forearm there was a similar deposit, a short distance above the wrist. On the left half of the scalp, two inches above and slightly behind the ear, there was also a plaque, almost circular in contour and about half an inch in diameter. The face was free from deposits, as were also the mucous membranes of the mouth, the skin of the neck, the palms, the soles and the right arm. The child had six teeth and was bright and intelligent.

The size of the anterior fontanelle was normal for a child of fifteen months. There was no sign of rickets, syphilis or achondroplasia. Neither the father or mother nor any of the other children presented any abnormality.

PLATE XLIV.—To Illustrate Dr. Stopford Taylor's and Dr. Mackenna's Article.

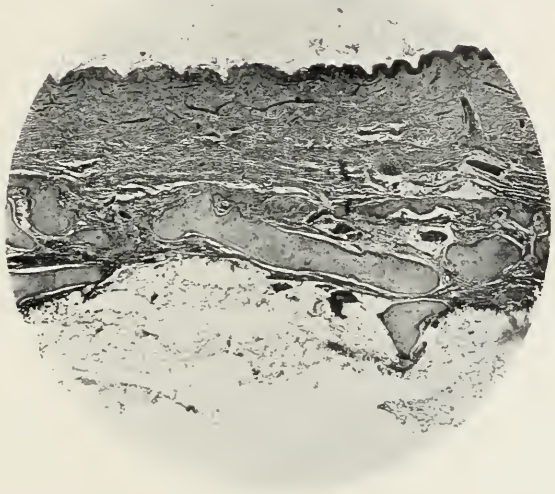

Fig. 1.

Fig. 2.

Under chloroform one of the plaques in the neighborhood of the xiphoid was removed for microscopical examination.

We are indebted to Dr. Frederick Wilson, Pathologist to the Hospital, for the following report:

PATHOLOGICAL REPORT.

"The specimen was decalcified and then embedded in paraffin. On microscopical examination the epidermis appeared normal. The papillary layer of the corium also was normal, but the reticular layer presented a loose rarified appearance, due possibly to some extent to the preparation of the specimen. In the lower part of this layer and projecting into the subcutaneous tissues were several plates of bone. These plates were irregular in size and shape and whilst for the most part were clearly differentiated from the surrounding tissues, here and there seemed to fuse with the connective tissue fibres. At these points the connective tissue fibres appeared swollen and blurred in outline and became more and more indistinct as they fused with the newly formed bone. Amongst these fibres were to be seen large cells, for the most part oval in shape. These were probably osteoblasts. The above condition was also to be seen in several isolated patches.

In the immediate neighborhood the ordinary connective tissue cells were increased in number.

The edges of the completely ossified plates were covered with a membrane of fine fibres and flattened out cells. The plates themselves showed true bone cells, concentric lamination and Haversian canals. There was no sign of any cartilage in the tissue.

Sweat glands and rudimentary hair follicles were present in the corium, but no sebaceous glands.

Owing to the irregular growth of the plates, islands of connective tissue, with sweat glands were here and there surrounded and cut off. The condition was evidently due to the development of membrane, bone and the process was still in progress."

The conditions are well seen in the accompanying low and higher power micro-photographs. (Figs. 1 and 2.)

This is one of the most remarkable cases which has come under our notice. In his excellent work on Antenatal Pathology and Hygiene, Ballantyne makes no mention of any case of the kind, and we are forced to conclude that alike in the experience of the dermatologist, the obstetrician and the embryologist the con-

dition is unique. In all probability the condition depended upon some aberration of development during intra-uterine life.

Unfortunately, we were unable to follow out the history of the condition for long, and to observe whether the osseous plaques developed pari passu with the development of the child. For about a month after we first saw the patient she contracted measles, upon which broncho-pneumonia supervened with a fatal issue.

To our regret we were not informed of this till more than a month after the child's death, so that we had no opportunity of performing an autopsy, which would probably have materially increased our knowledge of this interesting case.

TREATMENT OF ELEPHANTIASIS WITH THE X-RAYS

By Walter Booth Adams, M. A., M. D., Beirut, Syria.

ELEPHANTIASIS is a relatively rare disease in Syria. I have only five cases recorded in a total of 10,000 cases, one in my private and four in public practice. This is rather remarkable when one considers our proximity to Egypt, where it is a fairly common disease, and the constant intercourse with that country. Thousands of Syrians sojourn in Egypt to better their circumstances and return to their native land, and hundreds of Egyptians come to Syria every summer to enjoy the cool and salubrious air of the Lebanon mountains. These to some extent bring the endemic diseases of Egypt to Syria, but not so extensively as one would suppose.

The case of Elephantiasis Arabum presented has three unusual points I wish to note. These are the high altitude of the home of the patient and its remoteness from the coast and contact with people from Egypt; the unusual place of the lesion, the eyelid; and the new method of treatment by the X-rays.

My patient, Saïdy, is a married woman of about 30 years of age, has three children and her former history and family history are good, except that she was troubled with a chronic eczema, which she had had with greater or less severity for several years.

About five years ago she noticed a small papule on the upper eyelid near the inner canthus, but as it did not give any troublesome sensations she thought little of it for some time till it got so large that it finally completely closed her eye. She applied various domestic measures and astringents with no relief. At length she

came to Beirut for treatment. Her home is some four days away, 5,000 feet above the sea and near the great grove of the cedars of Lebanon. Four operations were performed by a German oculist in Beirut, accompanied with many promises but no benefit whatever. At length discouraged, she came to the clinic of my colleague, Dr. Webster, professor of diseases of the eye, who referred her to my clinic with the diagnosis of elephantiasis and the recommendation to try electrolysis of the small papule growing on the left lid, feeling that it was useless to attempt anything on the entirely closed and greatly hypertrophied right lid. The case was peculiar, a woman with two good, sound eyes, yet with blindness threatening her. The tumor on the left lid was growing rapidly, more rapidly than the one on the right eye had grown.

Instead of electrolysis I decided to try what effect might be obtained by X-rays. It was a leap in the dark. The first sitting was given to the tumor on the left lid through a spectrum fitting over it and so protecting the rest of the face. Two sittings were given in a week and when she came for the third improvement was noted in a softening and slight shrinking of the tumor and wrinkling of the skin. After the third sitting great improvement was observed, so much that the patient was delighted. After five treatments the improvement and shrinking and softening were so marked that I decided to treat the other lid, which was not in on the original program. A mask of sheet lead was made, covering all the face except the right eyelid and the inner half of the left lid, which had the now shrunken tumor on it. It was thought best to give it treatment with the other lid.

After two sittings were given to the right eyelid the swelling went down so that she could open it, a narrow slit enough for her to see out of. Seven more ten-minute sittings were given and the tumor grew steadily smaller. A slight dermatitis was set up after the ninth and the sittings were reduced to four minutes, and later increased to five and then to six minutes. Altogether 29 sittings were given, 15 to the right eye previous to the second photograph, and eight more were given after it was taken. Improvement continued, but it was not convenient to get a second picture, nor was the patient able to remain longer for further treatment. Altogether 87 minutes of treatment was given to the right eyelid before the second photograph was taken. The patient promised to return if the tumor should begin to grow again.

The diagnosis of elephantiasis was confirmed by Dr. Nucho, our professor of microscopy, who made an evening visit to the patient and found the filaria in her blood.

The question is, How did the X-rays do this work? Did they kill the embryos in the lymph channels in the eyelids and then absorption take place? I can not say. All I can say is that Saïdy was practically blind in one eye and expected soon to be blind in both, and departed with perfect use of both eyes.

There remained much fibrous tissue in the lid and the temptation to use fibrolysin was great. In fact, shortly before I had read Castellani's paper on the use of fibrolysin in elephantiasis, I made one injection, but made no more, as I wished to get the benefit of the X-rays without any complicating or assisting factor, and decided to reserve the injections of fibrolysin till later.

So far as I can learn this is the first use of the X-rays to this disease. I wish to report this palliative treatment, for it is possible that more extensive lesions may be benefited by it, and if it be combined with the further treatment of compression and fibrolysin injections as detailed by Castellani in a recent number of The Journal of Cutaneous Diseases, much more may be accomplished with this hitherto very intractable disease.

PLATE XLV.—To Illustrate Dr. Walter Booth Adams' Article.

Fig. 1.

Fig. 2.

SOCIETY TRANSACTIONS.

THE NEW YORK DERMATOLOGICAL SOCIETY.

358th Regular Meeting, May 26, 1908.

The President, Dr. Bronson, in the Chair.

Tuberculosis Verrucosa and Lupus Vulgaris. (Two cases). Presented by Dr. Whitehouse.

Dr. Whitehouse referred to the fact that at the November meeting he had presented a boy seven years of age suffering with disseminated lupus following measles. At that time some of the members thought it a case of tuberculosis verrucosa, but it seemed to be more of the lupus vulgaris type. It had existed for from one and a half to two years. He hoped to present the case again to-night to show the effect of treatment. The two present cases are shown believing they will be of interest in connection with the case above referred to. The man is 29 years of age, the boy 5. The man has tuberculosis verrucosia cutis following measles which he had when two years of age, and this condition has now existed for 27 years. The lesions are on the backs of the hands, the wrists, the forearms, buttocks, legs, and thighs. The most interesting lesion is on the foot extending to the sole. It is a typical case of tuberculosis verrucosa. The man himself is firmly convinced that the measles was the cause of this condition.

The boy has a patch of lupus vulgaris two inches in diameter and of two and a half years' duration, on the right cheek. He is the child of the man just presented, and the condition is regarded as an immediate inoculation from the tuberculous lesions of the father. The lesions on the backs of his hands have exuded pus between the warty outgrowths from time to time, and he admits that he has often wiped this away with his handkerchief, and that it was a common practice for him to blow the child's nose with this handkerchief. It was probably directly transmitted from the handkerchief to the child's cheek. While there is no history of any preceding skin affection of the cheek, it is not improbable that a simple chapped condition may have existed at the time of inoculation.

Dr. Whitehouse said that it was only in that light that he presented the cases—the unusual condition of two types of lupus in the same family, with a possibility of the one being inoculated from the other. He had never before seen a transference of this kind, and wondered if it was plausible that it could

have taken place as the father admits, and that the soil may possibly determine the clinical type of the eruption.

Case for Diagnosis. Presented by Dr. SHERWELL.

Dr. Sherwell said that this case would probably be interesting in connection with the two presented by Dr. Whitehouse, as it seemed to be of the same nature.

Edward M., age 27. Came to clinic Jan. 27, '08, with a lesion of a papulo-pustular character (similar to those now existing, only more severe). The original lesion appeared on the wrist about 4 years ago. At that time the patient consulted his family doctor, but the condition became steadily worse for 16 months thereafter. At that time the characteristic lesions had spread to the eye, neck, and nose. After that time began treatment at the Skin and Cancer Hospital. Some of the lesions improved moderately, but, not being satisfied, he after that tried one or two physicians and then applied to Dr. Sherwell's clinic. The neck and occiput were then extremely affected, also the nose, upper lip, and chin. The lesions on the back of the head and neck healed first and kindly under treatment with touching with acid nitrate of mercury in two months; the chin also was much improved, though taking a little longer time. The remaining lesions were more obstinate, but show great improvement during the last fortnight under increased vigor of treatment. The lesions have not been touched lately with the acid nitrate.

The condition seems to be similar to the cases described by Hyde and Montgomery, and is probably blastomycosis.

So far as known no microscopic observations have been taken by any one.

The patient has no luetic history. He is now being treated with white lotion, with a good deal of bichloride of mercury and salicylic acid.

Drs. DADE, JACKSON, FORDYCE, WINFIELD, and WHITEHOUSE concurred in regarding the case as a tubercular syphilide.

Dr. SHERWELL said that he did not think any of the members would have made such a diagnosis three or four months earlier. He was perfectly aware of the clinical appearance of the case at present, but the man had been under seven anti-syphilitic treatments without the slightest effect before he saw him, and later had been touched with nitrate many times, but did not respond to this treatment favorably. Under the present treatment the condition improved very rapidly, and besides he gave a clear history of a lesion of a similar character months before he had the lesion alluded to. He has had no other lesions of syphilis, no primary eruption, no falling of the hair, no headaches, nothing of the ordinary subjective or objective symptoms, excepting the ulcerative process. There has been no glandular affection. He has been a nuisance on account of his loathsomeness, but the condition while under treatment and the condition of the surface did not seem to be syphilis. He has a scar on the male organ, but no glandular affection. It has a most peculiar ulcerative surface, no hard borders like a breaking-down syphilis. He could not say definitely yet whether or not it was a blastomycosis, but he thought it probable. When the man first ap-

peared he made a tentative diagnosis of tuberculosis verrucosa cutis, for it looked more like that than anything else, and so, for that matter, does blastomycosis, though he has not seen many cases of the latter. He had not yet sent a specimen for microscopic examination, but had simply tried to cure the patient, and he certainly was much improved.

Case for Diagnosis. (A tuberculide?) Presented by Dr. DADE.

A generalized eruption of small papulo-pustular grouped lesions in the hair follicles, followed by minutes scars. The present trouble dates back four months, beginning with pain, headaches, fever, swelling and disability of the knees. At that time he was in the hospital for this joint trouble. The eruption is but slightly itchy. Abdomen is comparatively free—the face, back and limbs being well covered with the follicular eruption. He is still suffering some pain and swelling in the knees and ankles, for which he is receiving treatment. There are no lung symptoms. Patient has lost 35 pounds.

Dr. FORDYCE said he believed it to be a tuberculide. Objectively, it was a follicular inflammation leaving scars. Some of the grouped lesions over the trunk and arms suggested lichen scrofulosorum.

Dr. JACKSON said that he had seen the patient at his clinic in the afternoon, and believed it to be a tuberculide. Though resembling acne, it was too widespread for that disease, and, moreover, every lesion left a scar. It was an unusual case, and reminded him of the case Dr. Bronson had presented many years ago as one of acne cachecticorum. It seemed to him best to use the name tuberculide for all the cases reported under the designations of acnitis, folliclis, acne varioliformis, acne necrotisans and the like, our nomenclature being too voluminous.

Dr. WHITEHOUSE regarded it as a fairly typical case, though he had seen none with such diffuse patches; he thought there was a secondary dermatitis associated with it. The eruptions are distinctly follicular and leave scars. It belongs to the tuberculide type, but suggests lichen scrofulosum in many respects.

Dr. WINFIELD agreed that it belonged to the tubercular group, and suggested that the condition on the arms might be due to something that had been applied to it.

Dr. SHERWELL said that if the case had been seen in the old clinic of Hebra he thinks it would have undoubtedly been called lichen scrofulosum.

Dr. BRONSON said that he was not entirely satisfied with the term lichen scrofulosum as applied to this case. It seemed to lack some of the evidences of keratosis that usually appertain to that disease. A name which he thought fitted it better was the old-fashioned one of acne cachecticorum. That the patient was cachectic did not admit of question.

Lichen Planus. Presented by Dr. DADE.

The patient was a man presenting lesions on the back of the hands, forearms and legs. When first seen at the clinic two days ago the bullæ were sufficiently pronounced, scattered over the more typical lichen planus patches of the legs, to confuse the picture to the extent of having to take the hands and arms into consideration for a conclusive diagnosis. No

bullæ show at present, only the crusts remaining where he has torn open the bullæ for relief of the intense itching.

Dr. JACKSON said that he had seen the patient on Saturday and his condition then was so bad that he at first thought it a case of bullous erythema. It is the first case of this kind that he had seen.

Dr. JOHNSTON suggested that the formation of bullæ might be due to the aspirin which the man said he had been taking.

Dr. BRONSON inquired whether it was not possible that the friction resulting from the itching might not cause the bullous eruption. It sometimes does in urticaria.

Dr. JOHNSTON replied that that was the way that Dr. Allen used to produce it.

Dr. DADE said that the suggestion that the bullæ might be caused by friction should be taken into consideration, but the patient states that "blisters" appear and that he scratches and tears them open to afford him relief from the itching.

Lichen Planus on One Side. Presented by Dr. JACKSON.

The patient was a woman of middle age. The case presented nothing of interest beyond the fact that the perfectly classic lesions were only on one hand and wrist.

Dr. KLOTZ said that it was a very unusual case, and Dr. DADE said that it was the first case of the kind he had ever seen. He had a case, though, where the sole situation of the lichen planus lesions was the glans penis.

Keloid Following a Burn with Milia Scattered over the Face. Presented by Dr. J. A. FORDYCE.

The patient was a woman, 30 years old, who was burned about the face one year before. As a result, she had on the right side of the face a linear keloid about $3\frac{1}{2}$ inches long, projecting about $\frac{1}{8}$ inch above the skin level. The entire surface of the face, which had evidently received a burn of the second degree, was now covered by great numbers of milia. These milia were similar to those met with secondary to pemphigus and other bullous affections of the skin.

Fibroma Mulloscum. Presented by Dr. TRIMBLE.

The patient was a woman with small tumors over the entire body, which began on the chest when she was 16 years old. The lesions were connective tissue growths, soft variety—a number of them bladder-like in character. The duration was now about 30 years. It was a beautiful example of this condition.

Tumor of the Leg for Diagnosis. Presented by Dr. J. A. FORDYCE.

The patient, about 30 years old, stated that he had had a wart or mole on the anterior surface of his leg ever since he could remember. About two years ago he bruised his leg accidentally and hæmorrhage took place under the skin, leaving a persistent area of pigmentation cov-

ering a large surface. The "mole" since that time had taken on increased growth and now was the size of a small walnut, hard to the touch, with a smooth surface and non-pigmented.

Dr. Johnston said that the history did not seem clear. He did not think that the pigmentation was nævoid, nor did he think the growth an epithelioma. His idea was that it was a melanoma following a pigmented mole.

Dr. Whitehouse said that clinically he would diagnose the case as a degenerated mole. Only a microscopic examination could determine whether it was a melanoma or sarcoma.

Erythematous Lupus Cured by Liquid Air. Presented by Dr. Dade.

Dr. Dade said that he presented this case merely to show the result of treatment with the liquid air as compared with curetting. The patch on the left cheek was curetted some year and a half ago by a strong advocate of this method. The patient says that the process was so painful that she would not submit to having the patches on the right side so treated, besides it took three months before the wounds made by the curette had healed and a keloid scar resulted. Liquid air was applied to the right side patches at her request, and in two weeks the crusts had fallen, leaving the smooth white surface. The cosmetic result speaks for itself.

Dr. Jackson said that he did not remember having seen these lesions on the arms and back before when he saw her at his clinic. He thought there was little doubt as to the superiority of liquid air treatment over curettage in this case. In fact, he had had the misfortune to produce hypertrophied scars in one case of acne in which he had used the curette, and was not enthusiastic about its use.

Dr. Whitehouse said that the scars were good by both treatments, but perhaps better from the liquid air. He wondered whether the history of the lesions on the back would account for the swollen condition of the scars. The patient had spoken of these as being sore at times. Perhaps the pressure on the back produced the hypertrophic condition displayed by these scars.

Dr. Dade said that the patient stated that these scars would at times swell up, then subside. He did not think them the same process. The difference between the two sides of the face was only that one side presented a keloid and the other did not.

Epithelioma of the Tongue Healed by X-ray Treatment. Presented by Dr. Trimble.

Dr. Trimble said that he presented this patient from Dr. Fordyce's Clinic, to see whether any of the members had had a similar experience. The patient presented himself with a growth about the size of a lima bean on the left side of the tongue about two-thirds back from the tip. It was fungating and had much induration about it. The clinical diagnosis was epithelioma, although it had existed, so the patient said, for only three months. He was put on X-ray treatment as a temporary measure, although he had not known this to be used on the mucous mem-

brane of the mouth. The patient had two exposures before Dr. Fordyce saw him, and there seemed to be some improvement. At first he had exposures of two minutes; now he has had twenty exposures—the first two or three of less than five minutes, the others of about five minutes. They were given twice a week. The lesion has now healed up pretty well, and there is only a small white spot remaining. Dr. Trimble said that he thought the lesion must have existed for more than three months, though the patient says that that was the time he first noticed it. He wished to know whether the members of the society thought it justifiable to treat the case in this way instead of surgically. The man, however, had absolutely refused surgical treatment.

Dr. Winfield said that in the beginning of the X-ray treatment it was common to use the ray on all the mucous surfaces, but the results were so uniformly bad that now it is the general opinion that it is not wise to use it on any of the mucous surfaces. He had used it on a case of epithelioma of the tonsil for six months, and the patient continued to grow worse until he died. He had also a case of epithelioma of the tongue, a very small nodule, and used the X-ray—the patient refusing any other treatment—but the patient died. In fact, the X-ray seemed to aggravate the condition. This had also been the experience with a number of other cases. Dr. Trimble's case certainly shows a wonderful result for so few exposures and such short ones.

Dr. Fordyce said if any of these tongue epitheliomas could be cured by X-ray treatment it was certainly a great advance over the treatment by surgical methods. The majority of patients operated on for cancer of the tongue either died within a short time as a result of the operation or from recurrence of the original lesion. He was afraid, however, that X-ray treatment of epithelioma of the tongue would only very exceptionally result in benefit or a cure.

Dr. Trimble said that he was prompted to try this treatment on account of having recently cured a rodent ulcer affecting the upper and lower lips. Dr. Fordyce had presented the case earlier in the season. Up to the time when this patient was put under X-ray treatment his opinion had been the same as that of Dr. Winfield, and he had not thought the X-rays were of much benefit on lesions of the mucous membranes. The question now is whether or not the diagnosis was correct. The ulceration was almost the size of a man's thumb nail.

The only surgical procedure would have been the removal of the tongue, and that the man absolutely refused to permit. If all such lesions would heal as readily as this one has done, it would certainly be much better than the removal of the tongue, for, as Dr. Fordyce says, they recur very frequently.

Dr. Jackson inquired whether any of the members had used the Cornell tube. He thought it would be excellent for a case of this kind, as it could be put right against the lesion. It was claimed for it that there was no possibility of causing a burn. In one case where he had recently used it, there were two small superficial epitheliomas, which, to his surprise, promptly healed under three exposures, and there is now no sign of the trouble. The tube is placed in direct contact with the skin. The interrupter should be turned so that the current is broken much more slowly than while using the ordinary tube, as this tube is delicate, and intense currents are prone to break it.

Dr. Johnston said that exposures with the Cornell tube had cured a rodent ulcer the size of a silver dollar in the inner canthus of a patient in two months or less, the sittings occupying not more than five minutes, once a week.

Dr. Jackson said that where possible, operative procedures were the best.

The use of the X-ray took many sittings to accomplish a result that could be reached in a few minutes by the curette and caustics. It was useful specially in superficial and in inoperative cases, or where the patient preferred giving the time and paying the money to the pain and the disfiguring crust left by the operation.

Dr. Sherwell said that he had seen one or two cases where the X-ray had been applied as far as possible directly in the mouth without the slightest effect. He had two cases now in mind, one of them very bad, one of epithelioma at the base of the tongue, in which the X-ray had been used persistently without effect. It had been tried as offering a possibility of relief. The patient had had at first strong anti-syphilitic treatment to exclude the possibility of syphilis, and then the X-ray, administered by a very experienced man. He had never seen any good effect from X-ray treatment upon sarcoma or epithelioma or carcinoma on the mucous membrane in the mouth or throat or nose, nor indeed had he seen anything else do any good when deep seated. Operative interference, too, seems always fatal. One patient had the jaw severed at symphysis, the bones inverted, tongue removed entire, with affected or suspected adjacent tissues and glands, and without effect—a tremendous but good operation, but the man died. In another case of sarcoma the man died after the same operation.

He agreed with Dr. Morrow's remarks with regard to the removal of circumscribed tumors by direct methods, believing in their superior efficiency, economy of time, money, mental distress and many other reasons.

Case of Disseminated Lupus Following Measles. Presented by Dr. Whitehouse.

This patient was first presented at the November meeting, the lesions following measles a year and a half ago. One side was treated with a 20% plaster of salicylic acid and creosote and the other side with the X-ray. Most of the lesions have improved to about the same degree by both forms of treatment. Bier's hyperæmic treatment has been employed by means of an elastic band around the neck, but it has apparently aggravated the condition of the glands. As a result of the local treatment, however, there is a very great improvement. It was very difficult to treat the elbow, for the plaster would not remain in place.

Dr. Whitehouse said that he did not think the measles was the sole causative factor, but a number of these cases have been reported, and it is presumed that there is a tubercular focus in the individuals which the measles in some manner disseminates. It is possible that other infectious diseases might do the same thing. It is infrequent because of the large number of children having measles, but few have tubercular foci.

Affection of the Nails. Hereditary Syphilis? Presented by Dr. Whitehouse.

The patient is a young man of 19, in good general health, but suffering from trouble of the finger-nails since birth. The toe-nails have never been affected. His teeth were also very poor, and as far as can be learned never developed in a healthy manner. Four years ago they were all replaced by false ones. There has never been any other evidence of the disease. The young man works as a shipping clerk. He

is the youngest of five living children, having two brothers 30 and 28 years of age, and two sisters 22 and 21 years of age. The mother is living and well, with no history of miscarriages, but the father died about 18 years ago, and it was not possible to learn of what he died or anything of his personal history. All the nails of the left hand are affected, and the thumb and little finger-nail of the right hand. The other three nails of this hand, now fairly normal in appearance, had previously been involved in the same process. The nails are all discolored and very uneven, some being thin, split, and spoon-shaped, others thickened, distorted, and rigid. In places the process is advancing toward the matrix, with a yellowish outline to the diseased portion, accompanied by a crumbling and disintegration of the substance of the nail.

Dr. Jackson would not diagnose the case as one of syphilis. There were no other evidences of hereditary syphilis, neither keratitis, flattened nose, bosses on the forehead, or defective teeth. It seemed to him an atrophic condition that would do well under continuous treatment with arsenic internally, and local protection.

Dr. Dade said he recognized the man as one who had attended for some time the Vanderbilt Clinic. He states now that the three middle fingers of his right hand, which are free of any lesion at present, were cured by the salicylic acid and tincture of green soap treatment which he received at the clinic. It was then thought to be a trophic disturbance of the nails.

Tubercular Syphiloderm of the Nose, Extending Downward on the Right Cheek. Presented by Dr. Schwartz.

Dr. Schwartz said that he had presented this patient at the last meeting of the Society, and brought him again to show the improvement in his condition. He has had 16 injections, beginning with $\frac{1}{5}$ grain of bi-chloride of mercury hypodermically, working up to $\frac{1}{2}$ grain; and potassium iodide from 20 grains t.i.d. to 55 grains. There was not so much improvement as might be expected from a specific condition, and he would like suggestions from the members as to whether it would be better to continue this treatment or to try something else.

Dr. Klotz said that the case was very much improved.

Dr. Fordyce said when the case was shown at the last meeting he was inclined to think it lupus, though stating that it might be a tubercular syphilide. Since that time the treatment by injections of mercury and the internal administration of iodide had produced very little improvement. Some of the fungating lesions had disappeared from the surface, but the essential disease was still present.

Dr. Winfield thought it was lupus. With a month's treatment the case should have shown more improvement had it been syphilis.

Dr. Dade thought it a case of lupus.

Dr. Sherwell requested the attention of the Society for a few minutes, in order to make a demonstration of some photographs supporting the remarks of Dr. Morrow in regard to the efficiency of curettage in epithelioma.

Both cases were operated on over six months ago with curettage and acid nitrate.

No. 1. A lady over 60. Epithelioma of inner side of the orbits and nose, involving both tear ducts. The woman was operated upon seven months ago, and the picture was taken only a few days since. Operated on by the curette and the application of acid nitrate of mercury. In this case the dry scab remained two months; the paquelin cautery was needed at time of operation to check the hæmorrhage. The entrance of the tear ducts was scraped away on both sides, and then the acid nitrate was applied under ether anæsthesia. The scab was very deep and involved the bone of the orbital plate of the superior maxilla and the nasal bone, and was everywhere touched quite freely for about twenty minutes with the acid nitrate. The eye was protected by a pad moistened with solution of bicarbonate of soda.

In the other case, No. 2—a man about 60—the lid was everted, and the lesion was scraped as far as could be done; then treated for twelve minutes with acid nitrate before neutralizing with soda. Local cocaine anæsthesia.

Dr. Sherwell said he thought this was the better operation, and the thing was gotten rid of at once. The woman—Case 1—had a year's treatment by the X-rays, at least forty exposures, and other treatment beside. Had already at first been lightly curetted, and which simply took the top off, and then she had the X-ray treatment. Neither did good. One at a casual glance now would hardly notice scar or cosmetic deformity, yet the curettage and destruction of tissue had been great.

Dr. Sherwell said that he presented these pictures to show how this treatment could be successfully applied in these delicate and dangerous situations.

NEW YORK ACADEMY OF MEDICINE.

Section on Dermatology.

Stated Meeting, held April 7, 1908.

Dr. A. R. Robinson in the chair.

(*Concluded from page 434.*)

Tuberculosis Verrucosa (?) of the Palm. Presented by Dr. Howard Fox.

The patient is a negro, 42 years old, an elevator man. Since boyhood he has had a "seed wart" upon the left palm. This was treated three years ago by acids and a partial cure was effected. He did not continue treatment on account of the pain it occasioned. A few months later the lesion began to increase in size, and from a pea-sized area has enlarged till it now measures one and a half by three-quarters inches. He has

had no other treatment except occasional applications of corn cures. Three and a half years ago he suffered from cough and bloody expectoration and lost considerable weight. He was practically cured by a trip to the South. The lesion is a circumscribed mass of rough and horny elevations. It is dry and does not present any inflammatory symptoms.

Dr. Gottheil said that the lesion was not characteristically tuberculous. The hand was irritated by work; and the general appearance of the lesion, especially its carcinate character, was strongly suggestive of syphilis.

Dr. Lapowski said that the lesion did not look like either tuberculosis or syphilis, but rather like a simple product of irritation. He suggested the use of a chrysarobin ointment which would remove the hypertrophied epidermis,—which probably was due to the manual work of the patient, he being an elevator man,—and have a smooth surface, thus excluding both syphilis and tuberculosis.

Dr. Trimble said that he did not think this lesion due to local irritation. Should the therapeutic test be applied in this case he advised constitutional antisyphilitic treatment, and no local treatment at all.

Dr. Pollitzer said that this was not a case of tuberculosis verrucosa cutis because the cutis itself did not seem affected, there being simply a heaping up of horny cells. He would not make a diagnosis of syphilis from this lesion alone, and the test of treatment, to be valuable, should consist of four weeks of injections. Palmar lesions in which parakeratosis is the dominant clinical feature are so confusing that a diagnosis is often impossible from local lesions only.

Sycosis treated by the X-ray. Presented by Dr. Howard Fox.

The patient is 24 years old, an iron worker, born in Russia. Two and a half months ago he presented a chronic sycosis barbæ of two years' standing which had resisted treatment by various ointments. He was given thirteen exposures to the X-ray during a period of two months. The exposures to rather hard tubes have averaged five minutes each, the tube distance being eighteen centimeters. The treatment was not pushed to the point of producing dermatitis. Improvement began after the seventh exposure and complete epilation followed the eleventh exposure. The bearded portion of the face is now smooth, hairless, and entirely normal in appearance except for a slight remaining redness. He has been advised to keep the beard closely shaven for a year to aid in preventing a relapse.

Dr. Gottheil said that by epilation, under anæsthesia if necessary, with dressings of bichloride or other antiseptic solutions, the same result could be obtained in two weeks, with less expense and without danger.

Dr. Pollitzer said that there are few diseases so rebellious and also so variable as sycosis. It recurs after all treatment. He had seen a case treated by the X-ray to the production of apparently permanent alopecia, and some atrophy of the skin, and which had had every kind of local treatment and a course of opsonins also: yet pustules recurred.

Dr. Robinson said that he believed the X-ray to be of very great help as an adjuvant, and especially for its stimulating action.

Dr. Howard Fox, closing the discussion, said that he had treated the case slowly in order to avoid ill effects such as telangiectases, atrophy or permanent loss of hair.

Keloid treated with the X-ray. Presented by Dr. Clark.

The patient is a girl 20 years old, American by birth. She is said to have had some heart trouble since childhood and now has a systolic murmur at the apex, from which she suffers a little on any considerable exertion. There is no history of keloid in her family. One year ago the patient cut her elbow with glass. It was not stitched but was allowed to heal by granulation, with subsequent formation of a keloid which was tender on pressure and painful when the arm was flexed. The keloid was excised and the wound sutured. It healed by primary union, but directly a larger keloid formed along the line of union and at the points of entrance and exit of the sutures. This was again excised five months ago because of pain and tenderness, but a third and larger keloid rapidly formed, which soon became tender on pressure and caused radiating pains up the arm, which often prevented sleeping and greatly incapacitated the patient for work.

When I saw the patient three months ago she had a tender keloid mass the size of a split walnut which had been causing her considerable suffering for the past month. She was given three X-ray exposures at intervals of five days with some relief of pain and tenderness, but not until after six exposures, with some slight dermatitis resulting, did the growth began to diminish in size. The patient has had in all eight exposures to the X-ray with a complete disappearance of pain and a flattening of the growth to the skin level, except at the suture points, and these are rapidly diminishing.

Epithelioma of the face. Healed with one long X-ray exposure. Presented by Dr. Clark.

The patient is a female, 29 years old, American. The family history is negative. Ten years ago she received an injury to the area that two years ago became the seat of disease. The skin and complexion are normal. Two years ago a small spot that the patient had noticed for some months, below the inner canthus of the eye, became itchy, and after scratching it, she noticed a small scab there. This scab would fall off and re-form, and latterly the ulcer after the scab had fallen off would bleed a little. This condition persisted until one year ago, then there was a scabbed ulcer the size of a twenty-five cent piece which appeared as a typical epitheliomatous ulcer when the scab was removed, with raised hard pearly edges and a slightly excavated base. This ulcer was moderately superficial, and that together with its location made it well suited for X-ray treatment. Accordingly one prolonged exposure was given with a moderately hard tube localized to the epitheliomatous area, with the idea of producing a decided inflammatory reaction but not a burn. The patient was instructed to use a cooling salve for the redness and to report in three months if all went well. At the end of that time the ulcer

was entirely healed with a level pigmented scar except at the very lower edge which had not been included in the exposure. As this had been slowly diminishing in size it was left for further observation. Now after one year there is a perfectly hard white scar with no telangiectasis, and there is only a pin head sized pearly nodule left at the lower edge. To this I will give one prolonged localized exposure, which will undoubtedly remove it within six weeks. I recommend the method in all superficial epithelioma and in lupus, because of the quicker result that follows, a greater certainty of destroying the cancer cells, and a consequent less liability to recurrence.

Prurigo (Hebra). Presented by Dr. TRIMBLE.

The patient is a girl, 13 years of age. The disease is located on both upper and lower extremities and on the forehead. It began ten years ago as urticarial lesions, and has gradually increased in severity. Papules, scarring, and pigmentation are now present.

Prurigo (Hebra). Presented by Dr. TRIMBLE.

The patient is a boy 16 years of age. The disease has existed since infancy, and is located chiefly on the upper and lower extremities. There are a few lesions on the trunk, but practically none on the forehead. At the present time a number of pus infections are mingled with the lesions of prurigo. The lesions are very similar to those of the previous case—papules, scars, and pigmentation.

Dr. LAPOWSKI said that these were not cases of prurigo, as that disease was first described by Hebra, in which disease pustules never develop on the lesions. On the other hand, they correspond very well with Prurigo Hebra as described by the French school.

Dr. CLARK said that a lack of development in the child and a thick, pasty skin were almost universal in prurigo of Hebra, and that neither of these cases corresponded to that type.

Dr. POLLITZER thought that one of them was an average mild case of true prurigo, but that the other was not a case of prurigo at all, on account of the absence of lesions from the forehead and the presence of suppurative lesions.

Dr. TRIMBLE, closing the discussion, said that a case lasting so many years with such characteristic shotty papules, punctate scarring, pigmentated spots, secondary infections and intense persistent itching, could hardly be called mild; and that it was not necessary that the lesions should always occur on the forehead, although they frequently did occur in that locality, as was evidenced in one of the cases presented.

Naevus Pigmentosus (?). Presented by Dr. ROBINSON.

The patient is a male, aged 28 years; occupation, clerk. His general condition is fair, he is of a rather nervous disposition. He never suffered from any special illness. The present disease commenced four years ago, on the left, upper scapular region, and gradually extended downward until at present it reaches nearly to the lower part of the scapula. It

occupies an area about ten inches long, and triangular in shape, the broader part upwards and about six inches wide. The upper half is diffuse in distribution, the remainder is made up of isolated lesions varying from a pea to a thumb nail in size. The appearance of the eruption is like an ordinary light colored chloasma, or tinea versicolor, and close examination of the skin shows no sign of atrophy, no elevations above the normal skin, no scaling, itching or other subjective symptoms. He had been lectured upon by some teachers and exhibited as a case of tinea versicolor, but microscopical examination excludes that disease. It is true that the isolated lesions resemble this disease most closely, and I regarded it as probably such until I made a microscopical examination. The disease has ceased to spread since about one and a half years ago. Histologically, the only change to be observed was increased pigmentation, limited to the basal layer as in chloasma or Addison's disease. There were no "nævus cells" to be observed. The case is shown for diagnosis as the course of the disease and the location is unusual for a chloasma.

Dr. Pollitzer, after hearing the pathological report, disagreed with the diagnosis of nævus. He considered it a mere pigmentation, probably secondary, and perhaps a result of irritation, as from applications made for sunburn. The absence of nævus cells in the cutis certainly excludes the diagnosis of nævus.

Dr. Robinson, closing the discussion, said that several writers, especially the French school, agreed that it is not necessary to find nævus cells in every case of nævus. Dr. White of Boston, who had seen this case, was sure that clinically it was nævus. The case is not one of simple pigmentation as in chloasma as shown by the increased growth of hair in some parts of the affected area, neither does he regard it as a case of nævus, unless the term includes different pathological conditions. For those who regard the presence of "nævus cells" as essential factors in the growth, this case is not one of nævus.

NEW YORK ACADEMY OF MEDICINE.

SECTION ON DERMATOLOGY.

Stated Meeting, held May 5, 1908.

Dr. A. R. Robinson in the Chair.

Extensive Lupus Vulgaris. Presented by Dr. Howard Fox.

The patient is a woman, 44 years old, married, born in Ireland. When 15 years of age she first noticed a swelling on the left side of the neck which later broke down, continued to discharge for six years, and then healed. At the same age the eruption first appeared on the shoulder, knee and hand. Sixteen years ago she first noticed lesions on the neck in the neighborhood of the glands and later about the face. The lesions have slowly increased to the present time. She has increased in weight during the past sixteen years from 100 to 180 pounds. The lesions ulcerate at times and she then seeks hospital treatment. She has never at any time consented to any form of radical treatment. On examination the

nose, upper lip, and a considerable area of cheeks present dull red, dry, scaly lesions with raised and serpigenous borders. Patches have spread over both sides of the neck, leaving in places areas of remarkably smooth scar tissue. There are large serpigenous areas over the right shoulder, the left knee and the ulnar border of the left hand. The shape of the nose is fairly well preserved. The mucous membrane of the nose is also invaded.

Dr. Gottheil said that he had seen this patient many years before; and then, as now, she would not permit vigorous treatment. She then had, in addition to her lupus, a very abundant general pustular syphiloderm; he had photographs of the patient taken at the time.

Naevus Unius Lateris. Presented by Dr. Orleman Robinson.

The patient is a male, 17 years of age, born in Italy; his hair and complexion are dark. He is one of six children, and none except the patient has a similar cutaneous condition. The nævus dates from the time of birth. It is of a decidedly verrucous character in its entire extent and is markedly pigmented. It is limited to the right side of the body extending from above the ear to the lower third of the sternum. There is a break in the line on the side of the neck. The upper segment extends from above the ear to the middle of the neck. Its upper portion covers an area three inches in length and one and one-half inches in width. From this expanded area the nævus passes along the upper one-third of the posterior auricular surface curving downwards on the cheek two and one-half inches, where it abruptly ceases. The width of this portion is one-half inch. Another portion of the upper segment covers the middle one-half of the posterior surface of the ear and also the anterior portion, and extends over the lobule downwards and backwards on the lateral surface of the neck in a curved manner, when it suddenly passes downwards and forwards two and one-half inches, forming almost a right angle, to terminate about the middle of the lateral surface of the neck on a level with the cricoid cartilage. The lower segment commences over the thyroid cartilage and extends downwards slightly to the right of the median line almost to the end of the sternum.

Dr. Pollitzer said that he had a photograph of a case showing a very similar distribution, especially the curved line running down the neck from the ear, which is rather a common feature. He recommended excision of the linear lesions, leaving the ear alone.

Neglected Syphilis. Presented by Dr. Wallhauser.

The patient, a male, aged 16 years, was found occupying the cabin of a canal boat, where he had been confined for about two years without medical care. The only remedies he received consisted of various applications given him by acquaintances.

Family history. Father died of phthisis, the mother of typhoid fever. Two brothers and a sister are living, and in good health. The patient

was the youngest child. His father died one year after his birth. His mother was said to have had syphilis, but no definite history can be obtained as to whether it was contracted before or after the birth of the patient. About three years ago, the patient noticed an ulceration on the septum of the nose at its junction with the lip. Gradually it extended to the alæ, cheeks, forehead, etc. He is quite positive that he did not have a sore of any kind on any part of the body previously. The only abnormal condition he remembers was a swelling of the glands at the angle of the jaw, which was diagnosed as the mumps. Ulceration began about a week or so later. On admission to Newark City Hospital, March 14, 1908, almost the entire face was involved in a spreading tubercular eruption. The central portion had healed, while the borders were active and covered by thick black crusts. The lesion extended from the middle of the forehead across the lids, down the cheeks, to below the angle of the mouth, where the border turned upward involving the upper lip, following a similar course on the opposite cheek, back to the forehead, the two halves spreading out over the cheeks like the wings of a butterfly, as described in lupus erythematosus. The lower lip and chin were not involved. On account of sloughing of the tissues, the following conditions were present: There was an ectropion of the right eye. The left eye was entirely closed, due to pulling down of the upper lid by scar tissue. The nasal bones and cartilages had disappeared. The upper lip to the margin of gum had sloughed off, exposing the upper incisors, one of which, the right, was loosened and crowded over the left. There was an opening through the roof of the mouth through which the patient breathed, air gaining ingress through the mouth, as the nares have been entirely walled off by scar tissue. Since coming under observation, he has received intramuscular injections of mercury salicylate, and increasing doses of potassium iodide.

At the present time, May 5th, all active sloughing has ceased, and the patient is apparently well with the exception of the terrible deformity.

Dr. Gottheil said that he thought that in this case the history was a source of confusion rather than of help. The ectropion, the closure of the nares, the whole appearance of the face, was that of lupus vulgaris rather than of syphilis. The hard, red, dense, tumefied tissue of the face was not a scar left by syphilis: indeed, he believed the tuberculous process was still active.

Dr. Pollitzer said that at first glance the case was undoubtedly very suggestive of lupus vulgaris, but the course of the disease, its total duration of only three years, its healing in seven weeks under injections of salicylate of mercury, prove that it is syphilis. Contraction of the orifice may result from any destructive process. The photograph taken seven weeks ago shows active lesions: at the present time there is no single point on the face, no lesion, no nodule, no tubercle, nothing to show evidence of lupus.

Dr. Wallhauser, closing the discussion, said that the diagnosis in this case was based largely on the amount of destruction of the bony parts. Tuberculosis is a slower process, and even in extensive cases seems to avoid the bones: furthermore, the rapid recovery (seven weeks) should remove all doubt as to the diagnosis of syphilis.

Peripheral Syphilitic Arteritis with Clinical Symptoms of Raynaud's Disease. Presented by Dr. Howard Fox.

The patient is 33 years of age, single, Russian, a waiter. The family and previous history are practically negative. He suffered from gonorrhœa a year ago, but positively denies any other venereal disease. For the past nine months the toes and heel of the left foot have been constantly more or less cold and numb. From exercise or even standing, especially during the cold weather, the toes and heel would also suddenly become white, cold and stiff. They would remain in this condition for a varying time and would then become purplish and warmer. Eight months ago he had a severe attack of pain in the ball of the fourth toe. Three weeks later the skin broke, evacuating a little fluid, and leaving a sore that soon healed. Six months ago a hard lump half the size of a cherry was noticed on the inner aspect of the left leg. This lump disappeared after the patient had taken potassium iodide for two months. Treatment by inunctions and injections of mercury at Mt. Sinai Hospital (Dr. Lustgarten's Clinic) have produced decided improvement. No pulsation is felt in the posterior tibial artery of the left foot, whereas the pulsation in the right foot is normal. The urine shows one per cent. of albumin.

Pityriasis Rubra Pilaris. Presented by Dr. Cocks.

The patient, a negress 15 years of age, came to my clinic at the Harlem Hospital April 23d. The early part of March of this year a neoplasm was removed from the axilla, and one week later the present eruption appeared. There has been no increase of temperature. The whole body is involved. On the face and trunk the eruption is disseminated. The lesions on the arms, more especially the legs, are closely aggregated and consist of dry, hard papules, situated around the hair follicles. They are slightly brownish in color and if examined with a lens the broken hairs may be seen. Around the hair follicles a horny deposit has taken place and on the legs this deposit projects one-twelfth inch above the skin. The papules are not all of the same size, those on the face are smaller, not as hard and seem to be more inflammatory than those on the legs. The patient first noticed that the legs were rough and felt like a nutmeg grater, the eruption gradually spreading upwards. The face soon became involved. There have been no manifestations on the palms or soles. The younger lesions are capped with branny scales. The nails are not affected. In other respects the patient seems to be in a normal condition. There has been no pruritus.

Dr. Pollitzer said that the short duration of the disease was strongly against pityriasis rubra pilaris, which usually begins in infancy and spreads very slowly. Most of the lesions are absolutely typical of the lichen planus of Wilson. Mixed in with these lesions on the legs, which are œdematous, are those of purpura, and some of ordinary lichen pilaris also.

Dr. Clark said that some of the lesions on the legs showed the typical bluish color of lichen planus.

Dr. Robinson said he had not seen many cases of lichen planus in negroes, but he has a colored photograph of a case of general acute lichen planus, and he was quite satisfied that this case was not one of pityriasis rubra pilaris, but of lichen planus, as the lesions were not acuminated nor were they follicular lesions, but were the usual ones seen in cases of acute general lichen planus.

Dr. Cocks, closing the discussion, said that he was still unconvinced. He could not account for the conical lesions on the arms, the backs of the hands, and the face, on the theory of lichen planus. On the legs there were true horny plugs, not masses of scales, which could be scraped out with the curette. The center of many of the lesions showed an atrophied hair and piled up mass of débris.

BOSTON DERMATOLOGICAL SOCIETY.

February Meeting.

Dr. J. C. White in the Chair.

Dermatitis Exfoliativa. Presented by Dr. H. P. Towle.

Male, forty-eight, born in Italy. The patient came to the Massachusetts General Hospital, October 7, 1907. He stated that the eruption began two months before. The outbreak was attributed by him to bathing in salt water at the North End Park, because it appeared three days after the bath, and later was aggravated by a second bath. Beginning on the upper arms, the eruption involved in a few days the thighs, the back, the anterior surface of the body and, partially, the lower legs. The skin became intensely red and itching, and in a short time began to peel over the parts first involved, while the eruption continued to extend to other areas. The patient's general health has remained unaffected.

When first seen, except for small areas over the lumbar regions, the feet and face, the entire cutaneous surface was involved. The skin over the affected parts was of a bright, inflammatory red color, harsh and dry, swollen and covered with fine, thin, easily detached scales. The natural lines were much exaggerated; the skin felt much thickened and could be gathered up in great folds. The surface of the skin presented a papular appearance. At the borders of the affected regions were scalloped lines of thin scales, attached at their outer edges and larger than those over the inner portions. The skin just outside these scaling borders was bright red and somewhat infiltrated, but smooth and without scales. Scattered over the areas not yet uniformly involved were small superficially seated patches and lines interlacing to form a network of a paler red color and covered with small scales suggesting parapsoriasis.

In the further course of the disease the redness has gradually diminished and the swelling and scaling have disappeared, the oldest portions always involuting first. The process has ceased spreading, and, as will be seen, certain areas still remain free.

The scalp presents about the same appearances as when the patient was first seen, being covered with grayish, rather greasy scales, beneath which the skin is smooth and shining. The mouth and throat have never been involved. Itching has diminished with the disease in the intensity of the inflammation. The general health remains good. Nothing abnormal has been found in the internal organs.

Exfoliative dermatitis seemed a proper designation of the process on clinical grounds. As to the etiology of a majority of similar cases, we are as much at sea as we are with the pathology of gout and rheumatism. We assume the existence of faulty nutritional processes, decomposition of products the result of disturbed assimilation, etc., to be general causative factors, but it yet remains for biological chemistry to define these so-called diseases of metabolism of which the dermatosis in question is probably an example.

Syphilis? Post Scabetic Eruption. Presented by Dr. H. P. Towle.

In November, 1907, the patient presented himself with what was believed at that time to be scabies of a month's duration. He had numerous typical, small, scratched papules over the sites of election. Under the usual scabetic treatment the itching disappeared promptly and the papules subsided. As the eruption subsided, however, it was noticed that a different type of eruption was making its appearance. Over the upper extremities, especially upon their inner surfaces, there developed scaling areas which were best seen in an oblique light. Close inspection showed that there were present pale red bands about one-fourth to one-half inch wide, which interlaced to form a wide-meshed network. These bands which were scarcely visible on direct inspection were very superficial and covered with very fine white scales which were more abundant at certain points than at others, forming at these points small pea-sized collections. Scattered over the surface of these bands, irregular and often angular papules with smooth, shining surfaces could be seen when looked at from an angle. Similar indefinite papules developed upon the body, chiefly upon the sides, often also on the arms. Interspersed between these lesions were small deep red macules, whose color did not disappear readily upon pressure, but which in appearance strongly suggested a syphilitic roseola. In December there also developed a lesion in the throat which suggested a mucous patch, but which quickly disappeared. For a time the appearance upon the arms and trunk continued to become more and more prominent but then became stationary and, despite subcutaneous injections of mercury, have shown little if any change during the past four weeks. There has been no history of syphilis, and other than those mentioned, no signs.

Despite the suggestive resemblance of many of the lesions, the appearances present were regarded as relics of the previous scabies, aggravated by an over vigorous treatment.

A Case of Alopecia. Presented by Dr. C. M. Smith.

Man, æt. twenty-eight, married. The first area of baldness appeared two months ago and has slowly enlarged to its present size (about that of a dollar); it is situated on the lower part of the occiput, on the left side. Three weeks ago other areas of alopecia began to appear over the vertex and temporal regions. All the affected spots were smooth, free from scales, and covered only by a little lanugo hair. As a result of miscroscopic examination, the exhibitor was inclined to the opinion that the case was one of small sporé ringworm. The patient otherwise was healthy. There was no suggestion of syphilis either in his history or in his physical examination.

Consensus of opinion favored the diagnosis of alopecia areata in this case. The patient seemed too old to be infected with the microsporon Andouini, and furthermore, the absence of scales and broken off hairs was at variance with that affection.

Pityriasis Rubra Pilaris. Myxoedema. Presented by Dr. C. M. Smith.

Mrs. W., widow, fifty-four years of age. For the past six to seven years the patient has not been in good health. She first noticed that portions of her skin were getting dry and thickened. Then it was remarked that her speech was somewhat slow and labored, and that her gait was unsteady. At about this time also her hair began to fall, finally causing so much alopecia that she was obliged to wear a wig. In the spring of 1903 she was told that she had myxoedema and was prescribed thyroid extract with much benefit to both speech and gait. As near as she can remember the present condition of the skin began four years ago. It appeared first on the face and scalp, and soon extended down over the body. Early in 1904 she went to the Boston City Hospital, but she does not remember what her affection was then called. Although she has improved at times, the regions involved have never been right since the onset of the disease. At present the process seems to be constantly spreading, but is in general not so severe.

The skin was universally affected except for small areas on the arms and legs. The palms and soles became thickened early in the course of the disease, accompanied by dystrophic changes in the nails.

The entire affected surface of the skin was diffusely reddened, infiltrated, and closely studded with firm small papules, pin's head to small pea-sized. On the backs of the hands and extensor surfaces of the forearms, some of the papules were thought to possess small horny projections in relation with the hair follicles.

The patient stated that she had never perspired much and scarcely any for fifteen years. She complained of considerable pruritus and chilliness on the slightest exposure to cold or draughts. Heat also induced itching. Here and there, where the skin had been scratched, the

papules were abraded and sometimes crusting; in other regions the older papules were somewhat lustrous.

Under continued treatment with thyroid extract the general condition of the patient, including the dermatosis, gait, and speech, have much improved.

The diagnosis of myxoedema was accepted. No one, however, on the appearances presented by the patient and by the somewhat unsatisfactory examination by artificial light, felt willing to concede the proposed diagnosis of pityriasis rubra pilaris. Besides the latter affection, chronic eczema and lichenification of the skin were considered. No positive opinion was expressed as to the nature of the malady.

Dermatitis Herpetiformis. Presented by Drs. C. J. White and Burns.

This man (a negro) is thirty-six years of age. He was born in the island of St. Domingo, and until within the last year has always lived in the Tropics. Since boyhood he has followed the sea on various vessels plying among the West Indian Islands. Previous to the onset of the present affection he had never had any skin disease and his general health had been excellent. Little knowledge of the patient's anteeedents can be obtained.

He states that about six months ago he had an eruption on the skin like the present one, but milder and less extensive, which lasted two months, finally healing completely. There was then an interval of over three months during which his skin was clear. About two weeks ago. however, there reappeared on various parts of his skin an outbreak which he considers identieal in appearance to the first attaek.

When first seen, the man's appearanee was puzzling. He is of the black type of negro, which further obseured the analysis of his symptoms. There were generally distributed over his trunk and limbs aggregations of lesions which at that time could only be identified as crusts covering superficially denuded areas, varying in size from one-eight to one inch in diameter, with here and there confluence of the smaller lesions to form irregular and larger areas. Some of the older lesions, which were in proeess of healing, appeared as moderately infiltrated papules with rather lustrous tops. Between the affected portions, the skin, to all appearances, was normal. The patient said that the eruption burned rather than itched, and that he had little inclination to scratch. Many of the crusting lesions were abraded, probably from friction by the clothing, but there were no excoriations. Many of the elements looked as though they might have been primarily vesicular, but on closest inspection there was not an intact vesicle to be seen. The crusts seemed to be formed purely from inspissated serum, for there was nowhere any pus beneath or about them. The sites of predilection seemed to be the flexor surfaces of the arms and thighs, the abdominal and seapular regions.

The man's appearance was thought so interesting that he was admitted to the ward for skin diseases of the Massachusetts General Hospital. On the second day after his admission to the hospital a fresh outbreak of the disease occurred, which dispelled the uncertainty as to the nature of the disease, suggested by its obscure appearance when first seen. This relapse was purely vesicular and bullous in type, the lesions varying in size from pea-sized vesicles up to bullæ an inch in diameter. When fresh they were all well formed and tense with clear serous contents. As in the previous attack, there was a noticeable tendency to grouping, for on all the affected regions, there were more or less well defined irregular collections of lesions. The regions chiefly affected were the flexor surfaces of the limbs, the abdominal and scapular regions, and also several vesicles were clearly seen on the buccal and pharyngeal mucous membranes.

The interest in this case lay in the occurrence of dermatitis herpetiformis in the black race in which it had not previously been observed by this society. The symptoms of the disease seemed so well defined and characteristic that no doubt was expressed as to diagnosis.

Tuberculide. Presented by Dr. J. S. Howe.

This girl is sixteen years of age. For the past four years there have developed on her legs in winter, pustular and crusting lesions which in almost every case have run an indolent course of several months, finally healing and leaving depressed scars. The patient is quite positive in her statement that the outbreak has always developed in the winter and subsided in the summer. Where the crusts have accidentally been removed from the lesions, well defined, rounded ulcers, of some depth, have been exposed, which are noticeably pallid. It will be seen that the affection is confined to the legs and feet; very little occurring on the thighs. Distributed over the dorsa of both feet and legs are numerous small ulcers (crusting and open) and cicatrices varying in size from one-eighth to one-third inch in diameter. The ulcers are almost uniformly of the peculiarities above described. The cicatrices are thin, white, and depressed. None of the lesions have ever been very sensitive. So far as can be determined from her history and physical examination, she bears no stigmata of syphilis; neither is there history of tuberculosis in herself or family. Her general health has always been good except for sluggish circulation in the extremities, of which she has complained, in cold weather, since early childhood. It will be seen that the hands and feet are noticeably cold and passively congested.

Dr. Howe's diagnosis was thought most in agreement with the symptoms shown by the patient. It was suggested that this case would be an appropriate one for tuberculin treatment which had benefited several similar cases under observation during the past year.

Alopecia Areata and Ring-worm in the same Subject. Presented by Dr. C. M. Smith.

A girl, thirteen years of age, had been under occasional observation for four months on account of a typical alopecia areata of the scalp. The lesions of this affection were several in number, including one over the left temporal region 2 x 3 inches in diameter, which was particularly characteristic, possessing a bald, smooth surface over which exclamation-point hairs were detected. About a month after the patient's last visit she again presented herself, showing a new lesion on the vertex which differed from the previous ones in that it was covered by fine, dull scales. On examination of the scales and hairs from this area, numerous small, densely-packed spores were revealed, taken to be those of the microsporon Audouini. This lesion now differs but little in appearance from those of alopecia areata, except for some redness of the scalp.

Papular Syphilide. Presented by Dr. Abner Post.

This case was shown particularly on account of peculiar scaling papules on the back and abdomen, pin's-point to pea-sized, and covered by furfuraceous scales resembling in color and appearance lesions of tinea versicolor. Accompanying these lesions was a macular roseola, generalized over the trunk and limbs. Unusually large epitrochlear glands were both palpable and visible at each elbow. Dr. Post remarked that had he seen the patient for the first time by artificial light, he would have felt puzzled to distinguish the scaling lesions from those of pityriasis versicolor.

F. S. Burns,
Secretary.

THE PHILADELPHIA DERMATOLOGICAL SOCIETY.

The regular monthly meeting of the Philadelphia Dermatological Society was held at the Jefferson Hospital, on Tuesday evening, May 19, 1908, at 8:30 o'clock, Dr. M. B. Hartzell presiding.

Lupus Erythematosus Limited to the Lip. Presented by Dr. Stelwagon.

The patient was a male, 30 years of age. The lesion had first appeared three years ago, after the return from a trip to Iceland. The first thing noticed was a small slightly scaly spot, which felt somewhat rough to the patient, upon touching with the tongue. This small area had progressively, although slowly, increased in size. The lesion has, however, remained of practically the same dimensions for the last few months. It is situated upon the left side of the lower lip, extending from the median line to the angle of the lips, the vermilion border of the lip

and the inner surface of the mucous membrane of the same being, exclusively, involved. The lesion is dime-sized, almost annular, pinkish in color, with a slight shiny-white scale on the surface, somewhat infiltrated, sharply marginate, and of a "stippled" appearance. The area has been most resistant to treatment, but has improved somewhat under mild Roentgen treatment.

Acnitis, A Probable Case of. Exhibited by Dr. Stelwagon.

The patient presented was a male, 28 years of age. Until six months ago the man's face, according to his history, was without a blemish. The eruption appeared suddenly, most of the lesions came out in the one crop, although a few have appeared since then. In about one week after the eruption first appeared the disease was fully developed. The face was almost entirely involved, and excepting two lesions of the same character on the penis, the disease was limited to the same. The points of predilection seemed to be the eyelids and inner canthi, the cheeks at their junction with the alæ nasi, and the chin. The lesions consisted of bright-red and dull-red papules, and papulo-pustules, from small to large pinhead in size, mostly acuminate, but some flat, somewhat shiny in appearance, and some with a slight scale on the surface. The lesions tended to group, although there was but slight coalescence; linear formations were especially noted. Upon the disappearance of the lesions, deep irregularly shaped scars remained. Subjective symptoms were not prominent. The resemblance to syphilis and also to lichen planus was remarked. Dr. Schamberg at the April meeting showed a case of this unusual disease.

Epithelioma Developing in Lupus Vulgaris, A Case of. Presented by Dr. Hartzell.

The disease had originally started fifteen years ago, at the age of 49. The patient, a male, is well-preserved and apparently in perfect health. The first lesion noticed was a small reddish-yellow nodule, which appeared on the upper part of the left forearm. Other nodules developed until the present, double palm-sized patch was formed. One year ago a small ulcer appeared on the center of this patch, which rapidly increased in size. The patient at various times had these nodules cauterized, destroying some, but not preventing the spread of the disease. At the present time the patch extends from the elbow, flexure surface, one-half way down the forearm. Most of the patch consists of scar tissue, from the frequent cauterization. There is, however, around the margin of the lesion, reddish-yellow, deep-seated nodules. In the center of the lesion there is a fungating, papillomatous, one-half-dollar-sized tumor, from which oozes a somewhat purulent discharge. The interesting fact was also discovered that the epithelioma developed at the site of a mole. A biopsy made of the tumor showed an epithelioma with an alveolar arrange-

ment, as found in the structure of a mole. One of the nodules was also excised, but has not as yet been examined. The resemblance of the tumor to blastomycosis was remarked, because of the miliary abscess-like openings in the growth. The shape of the large lesion and the character of the scarring resembled markedly a tertiary syphilid.

Chancre of the Anus, A Case of. Exhibited by Dr. SCHAMBERG.

The patient was a negro boy, 11 years of age. Two months ago the initial lesion appeared on the left side of the anal opening. The small original papule developed into a dime-sized, sharply marginatet, raised, densely indurated lesion, with a moist, rough surface. The new-growth surrounded about one-half of the anal opening. Six weeks after the appearance of this lesion, or two weeks ago, the present eruption appeared. At the present time there is a somewhat general glandular eruption, the anterior and the posterior cervical being the most marked. There is a pharyngitis, and there has been "misery" in the muscles and the joints. A generalized flat, papulo-squamous eruption is also present. The palms of the hands and the feet are free. The eruption is most abundant on the trunk; most of the lesions being split-pea, and slightly larger, in size. The remains of the initial lesion can still be seen on the left side of the anal opening. The interesting history was discovered, that the probable origin of the initial lesion was from pederasty. A negro boy of 16 years had been in the habit of having anal intercourse with the present patient. Several other boys had supposedly been infected, in this same manner, by the boy of 16. The history was so clear that the source of the infection seemed to be proven, although the supposed infector has not been examined.

Bullous Eruption Following Vaccination, A Case of. Presented by Dr. SCHAMBERG.

The present patient, a male of 6 years, had been presented to the Society at the meeting held February 19, 1907. At that time the eruption had lasted about five months, and first appeared two weeks after vaccination. At that time the eruption was noted to have a symmetrical distribution, the flexures, the neck, and the genitalia being chiefly involved. The lesions were practically all bullous. During the last year and one-half the outbreaks have been almost continuous. When arsenic, however, was given the eruption entirely disappeared, but just as soon as the drug was discontinued a fresh outbreak occurred. At present the child has a severe relapse, not having taken any arsenic for some weeks. The eruption consists of bullæ on inflammatory bases. The lesions are now practically limited to the flexure surfaces; the wrists, elbows, axillæ, neck, chin, inner surface of thighs, the ankles, and the buttocks being the areas involved. The lips show a few bullous lesions, and the

tongue has also been attacked. There are no constitutional symptoms; the child appearing to be in the best of health. Those present thought that this case should be classed with those described by Bowen.

Bullous Erythema Multiforme, Unusually Localized, A Case of. Exhibited by Dr. SCHAMBERG.

The patient, a male of 36 years, was born in Poland. The present eruption started some weeks ago, with the appearance of the warmer weather. This is the third outbreak of the disease, the first appearing in the spring of 1906. Each attack has appeared in the early part of April, immediately after a few warm days, and has lasted until the cooler weather of the early autumn. In each outbreak the lesions have been limited to the ankles and the dorsal surface of the feet. The disease consists of an almost continuous crop of bullous lesions. At present the only active lesions consist of two bullæ on the outer surface of the left ankle. One bulla is hazel-nut in size, filled with almost clear fluid, it is tense, and is not surrounded by an inflammatory areola; the other is pea-sized, tense, and with hæmorrhagic contents. Both the right and left foot present pigment marks where the former lesions had been. Those present decided that the case should be classified under the erythema multiforme group, although atypical.

Hyperidrosis and Hyperaemia of the Face, A Case of. Presented by Dr. SCHAMBERG.

The patient was a male, 23 years of age, and born in Austria. He had always been healthy, and was of a muscular physique. The present condition had been present all of his life. There was a continuous moisture of the face, large drops of sweat being present even in the coldest weather. The small arterioles of the face were also distinctly visible. Marked hypertrophy of the parotid glands was a noticeable feature. The man complained of an excessive flow of saliva. There was also a congestive conjunctivitis on both sides. The dorsal surface of the hands, wrists, and the fingers showed a local stasis, being of a bluish-red color. Apparently the hyperidrosis was limited to the face. Numerous remedies had been tried with no effect. It was suggested that possibly the Roentgen ray might prove a benefit. Dr. Schamberg related the case of a patient, who suffered with a marked hyperidrosis of the axillæ, and who was markedly improved by the use of the rays.

In an informal discussion on the treatment of verruca, Dr. Hartzell related a case which had been entirely cured of almost one hundred warts, by the internal administration of magnesium sulphate, ten grains three times daily, for two weeks. Dr. Stelwagon referred to a cure of a like character, exhibited to the society some months before.

Dermatitis Papillaris Capillitii, A Case of. Presented by Dr. STOUT.

The patient was a white male, 20 years of age. The condition orig-

inally started about two years ago. A few deep seated papules first developed upon the posterior surface of the neck, these increasing in size and number. At the present time, there are about fifty deep seated papules, interspersed with small keloids, covering a space the size of the palm of the hand. The papular element is unusually marked, while the reverse is true of the keloidal. The condition has improved decidedly under strong salicylic acid plaster.

Epitheliomata Developing upon Keratosis Senilis, A Case of. Presented by Dr. Stout.

The patient was a male, 63 years of age. Ten years ago he first noticed the development of pigmented, slight scaly spots upon the face and hands. These areas increased in size, and became slowly more numerous. The patient has now fully one hundred pin-head to almost dime-sized yellowish-brown patches on the cheeks, dorsal surface of the hands, but chiefly the forehead. These lesions vary from almost smooth, non-scaly, to those which are rough, very scaly, and papillomatous. Two of these patches, the one on the right and the other on the left side of the forehead, have broken down, forming lesions with ulcerated centers and papillomatous circumferences. One of these lesions is one-half-dollar and the other one-quarter-dollar in size, and both are cauliflower-like in appearance. A strong pyrogallic acid plaster has proved of benefit. Those present agreed that the general practitioner does not realize how dangerous "old-age-spots" really are; in so many cases being the precursor of epithelioma.

Lupus Vulgaris, A Case of. Exhibited by Dr. Stout.

This disease first appeared in the patient seven years ago, at the age of thirteen. The growth, as in all of these cases, has been slow. The patient was born in Austria, exemplifying again that but few cases of lupus vulgaris occur in American-born children. The alæ and the tip of the nose, and the upper lip adjoining the same, were the areas attacked. The areas showed the typical reddish-yellow, "apple-butter" nodules, and an unusual amount of papillomatous growth, being fully one-sixteenth of an inch above the normal skin of the upper lip. Part of the left ala of the nose had been destroyed by the disease, and ulceration was still present. Fortunately for the girl, the disease is responding favorably to pyrogallic acid, thirty-three per cent. ointment.

Lupus Erythematosus Limited to the Face, A Case of. Presented by Dr. Stout.

The patient, a woman of 50 years, had first noticed this condition six months ago. At that time small, red, scaly spots appeared on the cheeks. These have increased in size, until both cheeks are entirely

covered by the patches. The lesions are not as sharply marginate as usual, there is not the "bat's-wing" arrangement over the nose. The eruption is very superficial, almost eczematous in appearance, with a white scale on the surface, dipping into the patulous ducts. The scalp is uninvolved, the disease being localized to the face.

Dr. Schamberg exhibited again the case of acnitis that is to be reported in detail at a later date. Microscopical sections of the case were also presented.

Frank Crozer Knowles, M. D.,
Reporter.

REVIEW
of
DERMATOLOGY AND SYPHILIS

Under the charge of A. D. Mewborn, M. D.

BACTERIOLOGY AND PARASITOLOGY.

By A. D. Mewborn, M. D.

Septicaemia due to the Bacillus Pyocyanous and true Chronic Buulous Pemphigus, (Septicémie a bacille pyocyanique et pemphigus bulleux chronique vrai), G. Petges and H. Bichelonne. *Ann. Derm. et Syph.*, 1908, p. 417.

The authors resume the very carefully described case of true chronic bullous pemphigus as follows:

1. A patient suffering from chronic pemphigus had developed spontaneous multiple abscesses, which upon incision allowed a blue pus to escape.

2. Patient had at different times a discharge of blue urine in which the classic reactions revealed the presence of pyocyanin.

3. By aseptic puncture of the veins at different times before death and by aseptic puncture of the heart post mortem, blood was removed which when inoculated upon appropriate media gave constantly a pure culture of the bacillus pyocyaneus.

These results were controlled and confirmed by Dubreuilh and Auché.

Clinically the case was one commencing with bullæ, which by their character, continual reproduction without itching, or other pain except when the raw skin was exposed by ruptured bullæ, the general toxic symptoms and evolution towards pemphigus foliaceus with fatal termination stamps it as a true pemphigus intermediate in type between the acute infectious pemphigus (type Brocq, Pernet, Bulloch) and chronic pemphigus evolving during years.

The authors consider that the cases of pemphigus vegetans described by Pernet and by Winfield, in which the first found the bacillus pyocya-

neus in the bullæ and the second found the pyocyaneus in the blood help support their argument as to the causal rôle of the pyocyaneus.

To resume the conclusions of the paper the authors find that:

1. The bacillus pyocyaneus may become pathogenic for man; it may bring about general diseases with or without lesions of the skin and diseases of the skin of apparent exogenous cause. In both cases it may cause bullous cutaneous reactions.

2. Near the false pemphigus, is the class of diseases catalogued under the generic name of true pemphigus (acute infectious pemphigus, chronic bullous, and pemphigus vegetant appears to be caused by infectious processes.

3. The bacillus pyocyaneus may play a rôle in the production of chronic bullous pemphigus and of pemphigus vegetant.

4. The case of chronic bullous pemphigus here reported was incontestably caused by a septicæmia due to the pyocyaneus. This case seems to bear out the law of Roger that "The same microbe may produce absolutely dissimilar clinical manifestations: clinical manifestations in appearance identical may be produced by different microbes.

Eczema Marginatum of Hebra (Sur L'Eczema Marginatum de Hebra, "Trichophytie Inguinale" et son Parasite, Epidermophyton inguinale Sabouraud). R. Sabouraud *Arch. d. Med. Exp. et D'Anat. Path.*, 1907, pp. 565, 737.

The author presents a very exhaustive study of the so-called Eczema Marginatum of Hebra and shows by incontrovertible evidence that before Hebra (1860) described the clinical picture in so masterful a manner, and before Köbner (1864) and Pick (1869) described the parasitic mycelium, that Devergie in *Maladies de la Peau* (1857), carefully differentiates the condition from intertrigo by the raised border (*bourrelet*) that he, known to be hostile to the idea of a mycosic origin of tinea capitis, nevertheless was inclined to regard the condition as due to a parasitic growth. The plate accompanying the text gives a drawing of the microscopical appearance of the scales from which Sabouraud says a diagnosis could be made to-day. The plate bears the title *Herpés inguinal microsporon.*

Sabouraud resumes his general conclusions as follows:

1. There exists a circinate and marginate dermatose, with large trichophytoid circles described by Hebra under the name of Eczema Marginatum, ordinarily localized in the fold of the groin and less often in other natural folds. A disease much more frequent in men, sometimes of acute evolution, but much more often of long duration with slight functional symptoms. A disease transmissible by sexual contact and which may in the absence of direct contact give rise to family and school epidemics.

2. We have found this disease invariably caused by the same mycelial

parasite having all the characters of a trichophyton except the negative character of not invading the hair. This parasite is distinct from all parasites which one may observe in the same regions and particularly from the *Microsporon minutissimum* of erythrasma. This parasite is cultivable upon appropriate media and furnishes a trichophytoid culture, botanically one of the principal characters of the family of trichophytons, its culture is characterized in addition by the rapidity of its senile degeneration and the rapid formation of the pleomorphic down. This culture as is true of many cultures of trichophytons, has not been successfully inoculated in man or in animals.

3. Sabouraud proposes to designate this disease under the name of Inguinal Epidermophytosis (*Epidermophytie inguinale*) and the parasite should be called the Epidermophyton Inguinale.

BOOK REVIEW.

A System of Syphilis, in six volumes. Oxford Medical Publications. Edited by D'Arcy Power, M.B. Oxon, F.R.C.S., and J. Keogh Murphy, M.D., M. C. Cantab, F.R.C.S., with an introduction by Jonathan Hutchinson, F.R.S. Publishers, Henry Frowde, Oxford University Press, London, 1908.

The great progress made in the study of this protean disease by the discovery of the spirochæte pallida, the causal agent, as well as the light thrown upon many obscure points by recent animal experimentation, fully justify the editors in bringing out this system of Syphilis by various authors. The handsome illustrations, many by half-tone reproductions of direct color photographs, the superior quality of paper and typography, are all most creditable to authors and publishers.

The Nestor of Syphilographers has introduced in the form of paragraphs many interesting themes for study as well as observation that are truly Hutchinsonian. For instance, where he refers to the resemblance of the spirochæte pallida of Schaudinn to the spirochæte pertenuis found by Castellani in *Parangi,* he says: "It is possible, however, that these apparent differences may prove to be more apparent than real. It may perhaps prove to be the fact that the spirochæte bred in different climates and in different races is capable of some modifications. These modifications may no more constitute specific characters than do the horns of a Scotch sheep or the hornless, dusky face of a well-bred Southdown. All our domestic sheep are unquestionably of one species, and in spite of their very conspicuous differences and the fact that they usually breed true, they may be crossed and are prone to revert."

Dr. Iwan Bloch, in the chapter on the history of syphilis, says: "All available statements and facts point to the last decade of the fifteenth century—particularly the years 1493-1500—as the time when

syphilis first appeared in the Old World. There is not a particle of evidence to show that the disease existed in Europe before that time." Hutchinson refers to this in the introduction as "a long and hotly debated question that may perhaps now be considered as finally decided."

Metchnikoff, in the chapter on the microbiology of syphilis, gives a very interesting account of the work that has been done (Hoffmann quotes 750 articles, Dec., 1906) in the study of the spirochæte pallida, and is really too modest in reference to the work done by himself in collaboration with Roux in the experimental inoculation of syphilis in monkeys. It is refreshing to find such genuine homage to the merit of Schaudinn, to quote, "We must consider it a particularly fortunate occurrence for science that the discovery of the ætiology of syphilis fell into the hands of a man like Schaudinn, a zoologist by profession, who before this work had proved his ability by his research on the spirilla of birds and that of relapsing fever in man."

The general pathology of syphilis is very clearly presented in the next chapter by F. W. Andrews, pathologist to St. Bartholomew's Hospital. The clinical description of the primary lesion and early secondary symptoms in the male are fully described by Colonel Lambkin, while the same subject as seen in the female is described by Shillitoe. Congenital syphilis is handled in the concluding chapter of the first volume by Dr. George F. Still.

The list of contributors to the remaining five volumes promises well for the high class of the entire system.

A. D. M.

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